IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005188

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Suspected Death of Peter Christofidis

Delivered On:	16 December 2024
Delivered At:	Southbank
Hearing Dates:	16 December 2024
Findings of:	Coroner Dimitra Dubrow
Counsel Assisting the Coroner:	Dr Declan McGavin, Coroner's Solicitor
Keywords:	Long Term Missing Person, Suspected Death

INTRODUCTION

1. Peter Christofidis was reported missing to Victoria Police on 14 March 1983 from his home address in Cheltenham. Peter was 27 years old at the time. Peter's vehicle was located a few days later at Hattah Kulkyne National Park near Ouyen in Victoria's northwest. However, Peter was never found.

2. On 17 September 2023, A/Sergeant Slagian Radoievici wrote to the Court to request that an investigation into the suspected death of Peter Christofidis be commenced.

THE CORONIAL INVESTIGATION

3. Coroner Katherine Lorenz (as she then was), initially held carriage of this investigation and on 9 February 2024 directed that the Court commence an investigation into the suspected death of Peter Christofidis. I took carriage of this matter upon my appointment in September 2024.

Purposes of coronial investigations

4. The *Coroners Act 2008* (**the Act**) requires coroners to investigate reportable deaths and to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[1] Reportable deaths include deaths that appear to have been unexpected, unnatural or violent or have resulted from an accident or injury.[2] For coronial purposes, death includes suspected death.[3]

5. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances Surrounding circumstances are limited to events which are sufficiently proximate and causally related and can include a finding that the suspected death in fact occurred.

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[1] Section 67(1), of the Act.
[2] See section 4 of the Act for the full definition of "reportable death".
[3] See section 3 of the Act for the definition of "death".

6. The purpose of a coronial investigation is to establish facts, not to cast blame or determine civil or criminal liability and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[4]

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.[5]

Investigation of Suspected Deaths

8. The coronial investigation of a suspected death differs significantly from most other coronial investigations which commence with the discovery of a deceased person's body or remains. The focus in those cases is on identification of the body or remains, a forensic pathologist's examination and advice to the coroner about the medical cause of death and the circumstances in which the death occurred.

9. Absent a body or remains, the coronial investigation focuses on the last sighting of the person suspected to be deceased; any subsequent contact with family or the authorities; and evidence of proof of life since.

10. In such cases, the coronial investigation is essentially an exercise in proof of death through the absence of evidence that a person has been alive or active via searches and a series of checks of records held by various authorities and databases.

Inquests into Suspected Deaths

11. The standard of proof for coronial findings or facts is the civil standard of proof on the balance of probabilities.[6]

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[4] Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[5] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.
[6] This is subject to the principles set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the

12. It is self-evident that a finding of a person whose remains have not been found is deceased is a serious matter with significant legal consequences that is not made lightly and requires me to reach a comfortable level of satisfaction as to facts based on the evidence.

13. In that regard, and in what is common practice among coroners, I considered it appropriate to use my discretion to hold an inquest on 16 December 2024. I did not consider it necessary to call any witnesses at the inquest as I was satisfied that the available evidence was sufficient cogent to allow me to make the required findings without the need for *viva voce* evidence.

14. At inquest, the Court heard through counsel assisting some additional comments and reflections from Peter's sister, Anna, about Peter and the investigation as a whole. I acknowledged her substantive involvement in the investigation at inquest and do so again now in this determination.

15. This finding is based on the totality of the material produced by the coronial investigation into Peter's disappearance and suspected death. In writing this finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity. The material will remain on the coronial file, together with the inquest transcript.

BACKGROUND

16. Peter was born in Cairo, Egypt, on 9 September 1955 to parents George and Garoufallia Christofidis. Both parents were born in Egypt but had Greek heritage and identified as such. The family migrated to Australia over 1956 and 1957 with their extended family before having another child, Anna, in 1958. Both parents are now deceased.

17. Peter's sister described him as a bright student in primary school but easily distracted, making people laugh. Peter enjoyed sports as a teenager playing football at his local club and later camping with friends. He left school aged 16 but returned to complete year 12 at Glenroy High School. The principal wrote that Peter was pleasant, co-operative,

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.''

responsible, courteous and always strived to do his best. Peter went on to La Trobe University, completing a Bachelor of Arts degree.

18. Peter's sister Anna described him as smart, charismatic, cheeky, effervescent, courageous, sad and anxious and that while he was hard to live with, made people feel safe and laugh out loud with his humour.

19. Peter reportedly grew up in a volatile household and experienced family violence as a child. He also had a history of alcohol use from a young age and got into some trouble with police. Later, during university, he commenced experimenting with other drugs such as LSD and cannabis. He travelled to India and reportedly used opium there and became increasingly paranoid.

20. Peter had a history of self-harm and suicidal ideation. On one occasion in April 1982, Peter locked himself in the bathroom and cut his left wrist. He required surgery as his left wrist sustained nerve damage and was subsequently admitted to an inpatient psychiatric facility.

21. During admission, Peter received six rounds of electroconvulsive therapy (**ECT**). He was diagnosed with depression and early schizophrenia and prescribed antidepressant medication.

22. Peter was discharged July 1982. However, following discharge, he retreated and locked himself away in the bungalow at the family home in Glenroy. He refused any visits and would only come out to eat and have brief encounters with his mother.

23. Peter had a history of disappearing for a few days at a time. Anna recalled one occasion when he went away for three or four days *"for a bit of a break"*.

24. On 30 August 1982, Peter was admitted to Graylands Hospital in Western Australia after he travelled on the Trans Australia Railway to *"get lost on the Nullabor somewhere"*. Upon arrival in Kalgoolie he wandered off into the bush with no food or water and was tracked by police and admitted to hospital.

25. Peter was prescribed anti-psychotic medication and his *"diagnosis was equivocal with elements of affective disorder and schizophrenia"*. Peter was discharged into the care of his mother with a plan for local psychiatric follow up back in Melbourne.

26. In late 1982, Peter's parents sold the family home and moved to Cheltenham.

CIRCUMSTANCES SURROUNDING THE DISAPPEARANCE

27. On 14 March 1983, Anna was visiting her parents. Her mother told her that Peter had stated that he was going away for a few days for a break. He had shaved his head, and Anna saw him driving away from the home at about midday.

28. This was the last time anyone saw Peter.

29. A few days later, police located Peter's vehicle at Hattah Kulkyne National Park, but there were no signs of Peter.

MISSING PERSON INVESTIGATION

30. The original missing person file was unable to be located. It is believed that Anna made the initial missing person report at Flemington or Moonee Pond police station. It is also believed that police performed an initial search of there area where Peter's car was found.

31. In December 2021, the Victorian Missing persons DNA Database came to Anna's attention, and she sent in an application form.

32. In September 2022, Anna provided a DNA sample to police which was sent to the Victorian Institute of Forensic Medicine (**VIFM**) to be uploaded and compared with the Victorian Missing persons DNA Database. There were no matches.

33. In May 2023, a media release was conducted appealing for new information. No new information was supplied as a result of the release.

34. On 17 August 2023, police performed a contact search the last known location of Peter near where police initial found his car in Ouyen. This did not reveal any new information nor were there any remains located.

Proof of life checks

35. Peter's extended family had three other members with the same name. Any matches to a Peter Christofidis in proof of life checks were attributable to a relative and not the missing Peter Christofidis.

36. Peter's bank book showed regular deposits and withdrawals from September 1981 until 7 February 1983. The bank account has not been accessed since. Police checks showed no new bank accounts opened after the disappearance.

37. Other proof of life checks did not result in any evidence that Peter was alive beyond March 1983 and included:
    a) Enquiries with Centrelink
    b) Medicare records
    c) Births, Deaths and Marriages – no change of name records
    d) Telephone records
    e) Immigration – no movement in or out of the country since arriving home from overseas in February 1981
    f) Australia Post

FINDINGS AND CONCLUSIONS

38. To this day, Peter has not been found, and a lack of any signs of life indicates that, on the balance of probabilities, he is most likely deceased. Having applied the applicable standard to the available evidence, and having held an inquest on 16 December 2024 at Southbank, I make the following findings pursuant to section 67 of the Act:

    (a) The identify of the deceased is Peter Christofidis born 9 September 1955;

    (b) The death occurred on or around 14 March 1983 from an undetermined cause; and,

    (c) The death occurred in the context of Peter's poor mental health after he left his vehicle and walked into the surrounding bushland near Ouyen having driven from his home in Cheltenham.

39. There is no presumption for or against a finding of suicide. Nevertheless, a finding that a person has deliberately taken their life can have long lasting ramifications for families and friends of that person. Therefore, it should only be made when there is clear and cogent evidence.

40. Peter had a known history of travelling out of town and seemingly lacked the insight and judgment because of mental illness to appreciate that this carried significant risk of serious harm or death. As such, I am not prepared to make a finding that Peter intentionally took his own life. Nonetheless, I find that Peter's mental health had significantly deteriorated which was causal to his disappearance and presumed death.

41. I wish to convey my condolences to Peter's family and to conclude by sharing some words that his sister Anna shared through Counsel Assisting at the Inquest:

> *Peter was an extraordinary human who was intelligent, witty, loving, cheeky and extremely protective of me and I am honoured to have had him as my brother despite some challenging moments. Peter made some negative choices that no doubt impacted on his wellbeing; however, his traumatic childhood had the greatest impact of all. When I think of him it is not always with sadness, I am able to remember childhood memories with a smile. My love for him is forever.*

Pursuant to section 73(1) of the Act, this finding is to be published on the internet in accordance with the rules.

I direct that a copy of this finding is provided to:

Anna Christofidis
Sergeant Slagian Radoievici

Signature:

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Coroner Dimitra Dubrow

Date: 19 December 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.